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Post-Traumatic Stress Disorder and Substance Use Disorder Co-occurrence in Female Veterans

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Introduction

Both Post-Traumatic Stress Disorder (PTSD) and substance use disorders (SUDs) touch the lives of many individuals. The female veteran population experiences a high level of trauma and PTSD (Zinzow, Grubaugh, Monnier, Suffolette-Mairel, & Freuh, 2007). PTSD and SUDs often co-occurr (Najavits, Weiss, & Liese, 1996). Given the fact that PTSD and SUD co-occurrence is high for the female veteran population, it is alarming that this population is currently growing (Zinzow et al., 2007). Given these three facts, the exploration of female veterans with PTSD and SUDs is of utmost importance if this population hopes to receive the best possible care offered by the counseling field.

Veterans with Post-Traumatic Stress Disorder and Substance Use Disorders

Veterans and Post-traumatic Stress Disorder

Combat exposure most obviously differentiates veterans from the general population. Exposure to combat and other traumatic military experiences relates to negative outcomes in regards to mental health issues (Hoge, Castro, Messer, McGurk, Cotting, & Kofman, 2004). The combat-related experiences and stress increase the risk of developing PTSD**.** With combat exposure comes an increased availability of traumatic experiences which military personnel, unlike the general population, may experience. In fact, the highest rates of PTSD involve individuals who witnessed atrocities (Sareen, Cox, Afifi, Stein, Belick, Meadows, & Amundson, 2007). Increasing exposure to these types of experiences increases the likelihood of developing PTSD. Combat-related atrocities may include involvement in a fire-fight, killing an enemy, witnessing the death of a comrade, and many other experiences. Over 90 percent of veterans report experiencing being shot at by enemies (Hoge et al., 2004). For veterans, the very nature of

their military duties, which involves likely exposure to active combat, create an environment which puts them at increased risk of PTSD development.

The impact of the military environment poses another important facet for a veteran population in regards to mental health. Several factors create an environment which does not help female veterans and perhaps induces a higher incidence of PTSD. Researchers have identified a group norm of sexual harassment tolerance which often exists among military officers (Lang, Laffaye, Satz, Dresselhaus & Stein, 2003). Additionally, some components of military culture, including drinking alcohol and engaging in unsafe sexual behaviors, increase the risk of assaultive behavior (Zinzow, Grubaugh, Monnier, Suffoletta-Mairel & Frueh, 2007). Individuals who experience military sexual abuse must also contend with a decreased ability to escape from situations which lead to PTSD symptomology (Lang et al., 2003). When an individual's assailant resides in the same sleeping quarters, victims often must continue to remain in this close proximity even after the assault (Zinzow et al., 2007). Further, just as racism exists in the general population, it is evident in the military as well. African American and Hispanic Vietnam War veterans exhibit higher rates of PTSD than White individuals due to fewer opportunities to succeed economically, higher substance use, and early stressors (Marsella, Friedman, & Spain, 1992). Therefore, the military subculture contains certain components which further increase risk of development of PTSD.

Certain trends arise regarding PTSD in veterans. As with the civilian population diagnosed with PTSD, poor physical health often results for veterans, including chronic health problems (Gulliver & Steffan, 2010). Medical conditions common to veterans with PTSD include a range of problems such as cardiovascular disease and pain. PTSD sufferers exhibit more physical medical problems than those without mental health problems (Frayne, Chiu, Iqbal,

Berg, Laungani, Cronkite, Pavao, & Kimmerling, 2010). Veterans suffering from PTSD also tend to have a more chronic and severe course to this disorder (Foa & Keane, 2000). Further, those with higher combat exposure display an increased number of PTSD symptoms (Sareen et al., 2007). Unfortunately, one common associated feature of this population is suicidality (Foa & Keane, 2000; Kang & Bullman, 2008). Possibly because of these issues, the treatment for this population in particular displays reduced efficacy (Foa & Keane, 2000). PTSD in veterans, a population particularly vulnerable to this disorder, expands beyond mental health and into the physical health of veterans.

Co-occurrence and the Connection to Substance Use Disorders

While the counseling literature indicates that PTSD and SUDs tend to co-occur, the causal relationship is unknown. One hypothesis involves the self-medication of PTSD symptoms through the use of substances (Gulliver & Steffan, 2010). By turning to drugs, individuals attempt to cope with symptoms such as painful emotions, terrible memories, and difficulty sleeping (International Society for Traumatic Stress Studies, 2001b). Of note, substance self-medication may actually prove adaptive at the onset of use (Center for Substance Abuse Treatment, 2009). However, long term detrimental outcomes occur (International Society for Traumatic Stress Studies, 2001b). A competing hypothesis suggests that both disorders share a common, yet unknown, source. A third hypothesis states PTSD and SUDs each increase the risk of the other (Gulliver & Steffan, 2010). An individual diagnosed with PTSD experiences a twofold increase in the likelihood of having an SUD compared to if they did not have PTSD. On the other side, those who have substance use disorders possess a greater chance of experiencing traumatic events (Najavits et al., 1996). The returning Operation Enduring Freedom/Operation Iraqi Freedom veterans experience co-occurrence at a rate of one-fourth to one-half (Gulliver &

Steffan, 2010). Current conceptualizations involve PTSD and SUDs viewed as two components of a larger issue (Gulliver & Steffan, 2010). Co-occurrence of these two disorders worsens the course of both disorders (Najavits, et al., 1996). As with PTSD alone, comorbidity with SUDs increases chronic illness and pain, which can lead to suicide (International Society for Traumatic Stress Studies, 2001b). While a veteran with PTSD suffers greatly, the presence of an SUD worsens the condition.

Barriers to Treatment

Barriers pose a significant concern for veterans considering treatment. Veterans tend to view treatment-seeking behavior as a weakness and perceive a stigma attached to a diagnosis involving mental illness (Schnurr, Friedman, Engel, Foa, Shea, Chow, Resick, Thurston, Orsillo, Haug, Turner & Bernardy, 2007). Veterans have been shown to fear this type of stigmatization twice as much as the general population (Hoge et al., 2004). Research has demonstrated that their fear that a mental illness diagnosis may result in being removed from military duty may have merit. Veterans therefore often do not seek treatment even when they wish to explore the option of therapy (Pietrzak, Johnson, Goldstein, Malley, & Southwick, 2009; Sareen, Cox, Afifi, Stein, Belik, Meadows, & Asmundson, 2007). Despite a need for help, veterans internalize this fear which perhaps explains why a minority of veterans seek treatment (Lang et al., 2003). Of note, those who highly need therapy most often believe that a stigma exists (Hoge et al., 2004). Veterans commonly report they fear a breach in confidentiality which relates to the aforementioned fear of stigmatization. Further, veterans may feel as though an outsider, someone who did not experience combat as they did, will not, and could not, understand them or their suffering (Sloane, Marx, & Keane, 2011). Military veterans truly experience barriers to treatment, even when desiring to seek it out.

The Role Being Female Plays

Greater Frequency

PTSD and SUDs are more likely to develop in women as opposed to men. These disorders impact women at higher rates, sometimes exhibiting as much as a two times higher prevalence rate (Najavits et al., 1996; Wellner, 2005). Female veterans exhibit this disorder even more, with a higher rate than the general female population (Schnurr et al., 2007). Further, chronic PTSD is four times as likely in females as in men (Tolin & Breslau, 2007). Both of these details might relate to the fact that female veterans more likely join the military with a prior trauma history (Lang et al., 2003). One study noted that around eighty to ninety percent of the female veteran population has experienced a traumatic event. Women experience sexual trauma and military sexual trauma more often than males. Many women feel as though they will be stigmatized if they do not go along with sexual advances by their male peers, which partially relates to the patriarchal military mentality. Additionally, over half of sexual abuse experienced by active duty female veterans occurred while the individual was on duty on military property. Military sexual trauma has been seen to lead to the greatest spike in development of PTSD symptoms (Himmelfarb, Yaeger & Mintz, 2006). SUDs commonly co-occur with PTSD in females and the majority of female veterans with PTSD have a SUD (Zinzow et al., 2007). Being female correlated to a higher rate of SUD and PTSD disgnoses.

Different Look for Females

The manifestation of PTSD and SUDs in female veterans differs when compared to their male counterparts. Females experience military sexual assault more often, but traumatic combat exposure less often, than males. However, females more likely witness injured or dead bodies in combat (Zinzow et al., 2007). Further, women in the military are more likely to have experienced

military-related sexual harassment (Hyun, Pavao & Kimmerling, 2009). Self-esteem is affected by these disorders for females in both general and female veteran populations. The military environment tends to be derogatory toward and less supportive of females, worsening matters for female veterans (Himmelfarb et al., 2006). Women feel the stigma and shame associated with traumatic experiences more than males, which may relate to the impact on self-esteem (Zinzow et al., 2007). Women also tend to utilize internalizing behaviors, self-blame, and suppression, which worsen PTSD symptoms, as coping mechanisms (Tolin & Breslau, 2007; Wolfe, 1993). Although the research on female veterans with SUDs is lacking, the literature notes that females with PTSD have significantly higher rates of reported substance use and abuse (Nunnink, Goldwaser, Heppner, Pittman, Nivergelt & Baker, 2010). Further, women with substance use problems have a tendency to be diagnosed less than appropriate and served less than deserved (Wellner, 2005). The PTSD and SUD experiences of female veterans differ from both those experienced by males and the general population.

Relationships

Relationships are a substantial focus for female veterans with SUDs and PTSD. With veterans, relationships are central for several reasons (Gladding, 2012). Studies suggest that women with PTSD and SUDs are unable to protect themselves, do not know how to refuse, have difficulties communicating, and lack trust (Najavits et al., 1996). Additionally, female veterans experience increased interpersonal violence (Zinzow et al., 2007). Domestic abuse commonly manifests in the relationships of veterans and figures may underestimate the true incidence as current statistics base their incidence rates on self-reports. Marriage problems and discord, experienced by half of couples with at least one veteran, lead to negative outcomes including precipitation of substance use and prevention of recovery (Sayers, Farrow, Ross, & Oslin, 2009).

Relationships with friends, family, and coworkers undoubtedly change after experiencing trauma, largely because of alterations in the individual's worldview. For example, those with a trauma history may expect danger and betrayal in relationships, can lose their sense of self, isolate, or experience drastic personality changes, all relating to relationship problems (International Society for Traumatic Stress Studies, 2001a). Relationship problems are common issues for female veterans with co-occurring PTSD and SUDs.

On the opposite side of the spectrum, healthy relationships can positively impactful the female veteran with co-occurring PTSD and SUDs. A partner's support can aid in the recovery of female substance users (Center for Substance Abuse Treatment, 2009). Active duty female personnel experience less PTSD than those who have been returned to civilian life as veterans, suggesting that social support may play a large role in regards to their mental health (Wolfe, 1993). Social support consists of three components: actual support given to the individual, the support the individual believes is available to them, and the relational quality they experience. Perceived support appears to be most significant in lessening the PTSD symptoms experienced. Perceived social support leads to an increased level of psychological well-being which negatively correlates with trauma (Kaniasty, 2005). Especially for female veterans who seem to benefit from social support, perceived and actual social support may prove invaluable.

Negative Health Outcomes and Barriers to Care

Women with co-occurring disorders suffer from many related negative outcomes. Negative health behaviors relate to PTSD (Hyun et al., 2009). Women with PTSD suffer from even more physical health problems than men (Frayne, Chiu, Iqbal, Berg, Laungani, Cronkite, Pavao & Kimmerling, 2010). Issues this population may face include: reduced psychosocial function, increased number of hospital stays, homelessness, and suicide (Center for Substance

Abuse Treatment, 2009). Women who experience sexual or physical assault while serving in the military in particular experience a decline in quality of life due to health problems (Hyun et al., 2009). This population uses Veteran Affairs (VA) services less often than males due to stigma, shame, and a fear of secondary victimization associated with treatment, especially in the VA setting. A VA setting is even less desirable for female veterans when their assailants were other military personnel. This tends to lead to a lack of treatment-seeking behaviors even for physical illnesses (Zinzow et al., 2007). In fact, a minority of female veterans with PTSD seek out treatment (Lang et al., 2003). Women experience barriers to accessing healthcare which range from concerns about who will take care of their children to the fear of stigmatization associated with female substance abuse. Moreover, females with trauma histories do not necessarily want to surround themselves with males and report dissatisfaction with the services received from the VA and other health care setting (Wellner, 2005). The health-related impact of being a veteran endures on a long-term basis as women still exhibit poor health outcomes (Saddler, Booth, Nielson & Doebbeling, 2000). These barriers to care and negative health outcomes weigh particularly heavily on female veterans and further the need for specific treatment interventions.

Analysis of Current Literature

While the current increase in research into this population sheds light on the field, much more literature is needed. Research exists for each component of this population, females, veterans, those with PTSD, and those with SUDs, and in some cases research delves into combinations of these facets. However, while copious amounts of research exist for each component, research on female veterans with co-occurring PTSD and SUDs, specifically, still lacks. Problems with the generalizability of these studies thus continue to endure. For example, in some studies which examine PTSD, the co-occurrence of an SUD serves as an exclusion

criterion for the study. Additionally, studies addressing gender differences do not inform the field as much as hoped. To illustrate this point, while sex differences are known, the reasons for the differences remain unknown, proving difficult to ameliorate such differences. Future research should look into these issues in order to set forth a more complete research base regarding the female veteran population with co-occurring PTSD and SUDs. While few studies address how culture, in terms of race and ethnicity, influences PTSD and SUDs in female veterans, culture is not ignored. For example, the military culture, to which all veterans belong to some degree, contributes to an altered experience of PTSD and SUD co-occurrence. Research on the military culture's influence abounds. Another factor rests in the role of the female culture for this population. The literature does well in looking at the role the female culture plays in PTSD. However the role it plays in substance use remains an area in need of more exploration. Further, the female veteran culture bestows compounded and additional differences in the manifestation of PTSD and SUD comorbidity. While research into the female veteran with co-occurring PTSD and SUDs grows, much remains unexplored.

Summary

Post-traumatic stress disorder and substance use disorders co-occur at a high rate and lead to an increase in morbidity, especially for veterans. For a female veteran, co-occurrence rates are even higher, compared to both their male counterparts and civilians, and the outcomes are worse. The manifestation of this particular combination of disorders looks different in female veterans, especially regarding relationships, negative health outcomes, and barriers to care. The central focus of female veterans with co-occurring PTSD and SUDs remains a fertile ground awaiting the counseling field to delve deeper and uncover more research, particularly aimed at providing better care for this population.

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